		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045781

Facility Name: Odin HealthCare Center

Address: 300 N. Green Street (Number) Odin (City) 62870 (Zip Code)

County: Marion

Telephone Number: (618) 775-6444 **Fax #** (618) 775-6964

IDPA ID Number: 35-1921817003

Date of Initial License for Current Owners: 06/07/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Chris Henderson **Telephone Number:** (832) 467-6307

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Greg Williams
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,078	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,156	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	501	146	7,557	8,204	8
9	SNF/PED					9
10	ICF	18,437	5,434	30	23,901	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,938	5,580	7,587	32,105	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.60%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/07/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 7,540

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Odin HealthCare Center # 0045781 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	141,592	10,415	14,698	166,705		166,705		166,705			1
2	Food Purchase		133,847		133,847		133,847		133,847			2
3	Housekeeping	76,203	13,128		89,331		89,331		89,331			3
4	Laundry	45,404	9,348	4	54,756		54,756		54,756			4
5	Heat and Other Utilities			100,345	100,345		100,345	166	100,511			5
6	Maintenance	28,216	20,633	7,207	56,056		56,056	91	56,147			6
7	Other (specify):* Waste/Garbage -See pg 3.1			19,560	19,560		19,560		19,560			7
8	**TOTAL General Services**	291,415	187,371	141,814	620,600		620,600	257	620,857			8
	B. Health Care and Programs											
9	Medical Director			12,564	12,564		12,564		12,564			9
10	Nursing and Medical Records	1,371,254	95,938	14,218	1,481,410		1,481,410	20,205	1,501,615			10
10a	Therapy	465,282	35,508	21,417	522,207		522,207		522,207			10a
11	Activities	31,815	4,242	2,020	38,077	587	38,664		38,664			11
12	Social Services	38,207	153	2,334	40,694		40,694		40,694			12
13	Nurse Aide Training											13
14	Program Transportation		10	27,005	27,015	(27,005)	10	(10)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,906,558	135,851	79,558	2,121,967	(26,418)	2,095,549	20,195	2,115,744			16
	C. General Administration											
17	Administrative	88,649			88,649		88,649		88,649			17
18	Directors Fees											18
19	Professional Services			10,684	10,684		10,684		10,684			19
20	Dues, Fees, Subscriptions & Promotions			22,302	22,302		22,302	(9,174)	13,128			20
21	Clerical & General Office Expenses	85,194	12,595	310,263	408,052		408,052	(78,609)	329,443			21
22	Employee Benefits & Payroll Taxes			422,718	422,718		422,718		422,718			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,615	23,615	(734)	22,881	10,817	33,698			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,180	101,180		101,180	(49,143)	52,037			26
27	Other (specify):*											27
28	**TOTAL General Administration**	173,843	12,595	890,762	1,077,200	(734)	1,076,466	(126,109)	950,357			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,371,816	335,817	1,112,134	3,819,767	(27,152)	3,792,615	(105,657)	3,686,958			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	14,119
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	5,441
Garbage Service <> Default <> Physical Plant	0
	19,560

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

Meals - adjustment

32,105	Days (Total Patient days)
3	Mult (3 meals a day)
96315	Sub total
0	meals to employess (reported by facility)
96315	Add Sub
0	Divide -Pg 3, line 2, column 2
0.00	Cost per day
0.00	Cost per day
0	mult - meal to employees
0	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

133,847	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1338.47	Sub total
34.32%	Mult (Pvt pay div by total census)
459	x 1/2
230	= adjust for nonallowable sale tax for page 5A,

Reclassifiaction V

Page 3 Line 14
Res/Client Transportation<>Default<>Prod<>1 810004000003850 (27,005) Reclass From
Page 4 line 38 27,005 Reclass to

Page 4 line 30 Depreciation (1841) Reclass From
Van was used for 20% of time for medical
Depreciation Yr Van 9205 x 20 % 1841
Page 4 line 38 1,841 Reclass to

Disallowed Travel Expenses
20% of Van Expenses are reclassed
(Total Expense 734.39 x 20% = 147) 20% 147
80% 588 Line 11

Facility Name & ID Number Odin HealthCare Center #0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			134,762	134,762	(1,841)	132,921	64,194	197,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(2,583)	(2,583)		(2,583)	2,583				32
33	Real Estate Taxes			51,660	51,660		51,660	(9,657)	42,003			33
34	Rent-Facility & Grounds							7,270	7,270			34
35	Rent-Equipment & Vehicles			181	181		181	1,381	1,562			35
36	Other (specify):* Home Office							11,124	11,124			36
37	**TOTAL Ownership**			184,020	184,020	(1,841)	182,179	76,895	259,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					28,993	28,993	(28,993)				38
39	Ancillary Service Centers		180,521	3,894	184,415		184,415	27,784	212,199			39
40	Barber and Beauty Shops		16	1,571	1,587		1,587	(1,587)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* Lab/Xray Exp see pg 4.1		156	22,050	22,206		22,206		22,206			43
44	**TOTAL Special Cost Centers**		180,693	81,867	262,560	28,993	291,553	(2,796)	288,757			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,371,816	516,510	1,378,021	4,266,347		4,266,347	(31,558)	4,234,789			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	156
	156

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	16,859
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	5,190
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
	22,050

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(28,993)	38		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,153)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(269,713)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (299,859)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	268,302		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 268,302		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (31,557)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 28,993	14 & 30	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 28,993		47

Odin HealthCare Center

ID# 0045781

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (230)	21	1
2	Small Balance Adjustment		21	2
3	Memorium/ Benevolance	(889)	21	3
4	Depreciation Reconciliation	64,194	30	4
5	Activities Program Receipts		11	5
6	Property Taxes Adjust to actual	(10,249)	33	6
7	Professional liability Insurance	(49,143)	26	7
8	Barber & beauty	(1,587)	40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(10,053)	20	10
11	Entertaiment	(141)	24	11
12	Fresh Start		36	12
13	Civic Dues		20	13
14	Penalities		21	14
15	Vending reciepts	(2,376)	21	15
16	Misc Reciepts		21	16
17	Marketing Wages	(12,304)	21	17
18	Marketing Bonus	9,195	21	18
19	Marketing Holiday	(256)	21	19
20	Maketing Sick	(32)	21	20
21	Marketing Vacation	(539)	21	21
22	Marketing Overtime	(80)	21	22
23	Marketing Non Worked Wages		21	23
24	Donations/ Contributions	(275)	21	24
25	Legal Fees - Bankrupcty		21	25
26	Legal Structure Management Fees	(257,521)	21	26
27	Transportation	(10)	14	27
28	Undocumented Travel		24	28
29	Interest Income	2,583	32	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(269,713)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	166	0	0	0	0	0	0	0	0	0	166	5
6	Maintenance	0	91	0	0	0	0	0	0	0	0	0	91	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	257	0	0	0	0	0	0	0	0	0	257	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	20,205	0	0	0	0	0	0	0	0	0	20,205	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(10)	0	0	0	0	0	0	0	0	0	0	(10)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10)	20,205	0	0	0	0	0	0	0	0	0	20,195	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,053)	879	0	0	0	0	0	0	0	0	0	(9,174)	20
21	Clerical & General Office Expenses	(266,460)	187,851	0	0	0	0	0	0	0	0	0	(78,609)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(141)	10,958	0	0	0	0	0	0	0	0	0	10,817	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(49,143)	0	0	0	0	0	0	0	0	0	0	(49,143)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(325,797)	199,688	0	0	0	0	0	0	0	0	0	(126,109)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(325,807)	220,150	0	0	0	0	0	0	0	0	0	(105,657)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odin HealthCare Center # 0045781 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	64,194	0	0	0	0	0	0	0	0	0	0	64,194	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	2,583	0	0	0	0	0	0	0	0	0	0	2,583	32
33	Real Estate Taxes	(10,249)	592	0	0	0	0	0	0	0	0	0	(9,657)	33
34	Rent-Facility & Grounds	0	7,270	0	0	0	0	0	0	0	0	0	7,270	34
35	Rent-Equipment & Vehicles	0	1,381	0	0	0	0	0	0	0	0	0	1,381	35
36	Other (specify):*	0	11,124	0	0	0	0	0	0	0	0	0	11,124	36
37	**TOTAL Ownership**	56,528	20,367	0	0	0	0	0	0	0	0	0	76,895	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(28,993)	0	0	0	0	0	0	0	0	0	0	(28,993)	38
39	Ancillary Service Centers	0	27,784	0	0	0	0	0	0	0	0	0	27,784	39
40	Barber and Beauty Shops	(1,587)	0	0	0	0	0	0	0	0	0	0	(1,587)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(30,580)	27,784	0	0	0	0	0	0	0	0	0	(2,796)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(299,859)	268,301	0	0	0	0	0	0	0	0	0	(31,558)	45

Related Illinois Nursing Homes as of 12/31/2003

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 166	$ 166	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	91	91	2
3	V	39	Professional Services		Mariner Health Care	100.00%	27,784	27,784	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	879	879	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	20,205	20,205	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	187,851	187,851	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	10,958	10,958	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%			8
9	V	36	Depreciation		Mariner Health Care	100.00%	11,124	11,124	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	592	592	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	1,381	1,381	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	7,270	7,270	12
13	V	26	Property Insurance		Mariner Health Care	100.00%			13
14	Total			$			$ 268,301	$ * 268,301	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		$ 166	$	1	$ 166	1
2	6	Repair & Maintenance		1		91		1	91	2
3	39	Professional Services		1		27,784		1	27,784	3
4	20	Fees, Subscriptions, Promotions		1		879		1	879	4
5	10	Nursing & Medical Records		1		20,205		1	20,205	5
6	21	Clerical & General Office Exp		1		187,851		1	187,851	6
7	24	Travel & Seminar		1		10,958		1	10,958	7
8	26	Insurance Premium		1				1	0	8
9	36	Depreciation		1		11,124		1	11,124	9
10	33	Taxes - Property		1		592		1	592	10
11	35	Rental & Leasing		1		1,381		1	1,381	11
12	34	Leasse Expense		1		7,270		1	7,270	12
13	26	Property Insurance								13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 268,301	$		$ 268,301	25

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	49,874	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	41,411	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,463)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,123	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	51,660	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	42,472	8
	2000	43,844	9
	2001	44,438	10
	2002	44,623	11
	2003	41,411	12

4... G/L accrual for Property taxes and adjusted for rounding $1.00

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odin HealthCare Center COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045781

CONTACT PERSON REGARDING THIS REPORT Chris Henderson

TELEPHONE (832) 467-6307 FAX #: (832) 467-6349

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-11-400-001	00000000 PT SE SE	$ 20,705.31	$ 20,705.31
2.	10-11-400-001	00000000 PT SE SE	$ 20,705.31	$ 20,705.31
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,410.62	$ 41,410.62

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	269,000	1994	$ 80,743	1
2					2
3	TOTALS	269,000		$ 80,743	3

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1994	1995	$ 3,360,767	$ 96,022	35	$ 96,022	$	$ 1,014,902	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached -Page 12.1			1994	782,958	39,148	20	39,148		373,540	9
10	Repair Sidewalk #36 & 37			1996	819	41	20	41		298	10
11	Rooftop A/C - See attached page 12.2			1996	16,378	819	20	819		7,296	11
12	Install Awning			1997	2,845	142	20	142		973	12
13	Water Heater - See page 12.2			1997	1,388	69	20	69		528	13
14	Water Heater Installed - See page 12.2			1997	6,645	332	20	332		2,554	14
15	Electrical			1998	357	9	20	9		54	15
16	HVAC			1998	1,516	38	20	38		228	16
17	Plumbing # 67			1998	2,853	71	20	71		426	17
18	Water Heater # 69			1998	3,885	97	20	97		582	18
19				1999							19
20											20
21											21
22	A.O. Smith 75 Gal Gas # 72			1999	1,818	182	10	182		910	22
23	100 G Gas Water Heater # 77 & 78			2000	1,397	140	10	140		513	23
24	12: Zoneline HVAC Units #94 & 95			2000	8,579	572	15	572		2,002	24
25	First Q digital reset #98 & 99			2000	1,224	122	10	122		448	25
26	W/G & Maglocks system #102 & 103			2000	3,817	382	10	382		1,273	26
27	2200 SQ FT Flatroof Downpymt #104			2000	9,899	990	10	990		3,217	27
28	Wandergard System #106 & 107			2000	3,615	362	10	362		1,326	28
29	236' 4' High, DogEar Ceder Fence #109			2000	3,173	397	8	397		1,322	29
30	Instl 11,220 SQFT Flat roof #110			2001	20,098	2,010	10	2,010		3,029	30
31	Roof Shingles - 33% Downpmt #111			2001	18,277	1,828	10	1,828		5,178	31
32	Balance of Roof Replacmt #112			2001	36,553	3,655	10	3,655		10,052	32
33	9: Smoke & 2: Heat Detectors #116			2001	960	96	10	96		264	33
34	Use Tax 9: Smoke & 2: Heat Detectors #117			2001	62	3	10	3		14	34
35	R/T 3T Armstong Condense Int #118			2001	1,278	85	15	85		227	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	4: Maglocks & Indoor Keypads #119	2001	$ 3,057	$ 306	10	$ 306	$	$ 1,146	37
38	7: Zoneline HVAC - Patient Rooms #123	2001	4,718	315	15	315		1,075	38
39	Use Tax 7: Zoneline HVAC - Patient Rooms #124	2001	298	20	15	20		68	39
40	Charge Back - Excessive Discount #126	2001	442	29	15	29		98	40
41	5: Catch - All Digital Reset #127	2001	1,577	158	10	158		578	41
42									42
43	3: Wanderguard Auto 24Hr timer #144	2002	250	25	10	25		92	43
44	Cr Inv# 10017115 - 1; Auto 24 Hr timer #145	2002	(76)	(8)	10	(8)		(27)	44
45	Wanderguard System Unst'l #146	2002	2,680	268	10	268		983	45
46	6: Zoneline Heat/ Cool Units #5017	2002	4,111	822	5	822		2,124	46
47	Use Tax 6: Zoneline Heat/ Cool Units #5018	2002	260	52	5	52		134	47
48	Repair to Damage Brick #5030	2002	5,000	333	15	333		833	48
49	Arch fee -Upgrade to Skilled St #5033	2002	1,928	129	15	129		289	49
50									50
51	Prefinished Slab Door #5034	2003	495	33	15	33		69	51
52	SteelDoor w/Window # 5035	2003	693	35	20	35		72	52
53	15: Vinyl Rplc Window -Intsl # 5036	2003	7,500	500	15	500		1,042	53
54	Sentricon colony Elim -instl # 5051	2003	8,890	889	10	889		1,556	54
55	Arch/Eng Fee Skilled Care # 5054	2003	5,143	342	15	342		571	55
56	Cable - remote -WanderGuard system # 5059	2003	2,546	255	10	255		912	56
57	2: Maglock -WanderGuard # 5063	2003	(2,338)	(234)	10	(234)		(1,071)	57
58	6: Zoneline a/C Units A/C Heat Units # 5056	2003	3,434	687	5	687		1,030	58
59	Use Tax -6: Zoneline a/C Units A/C Heat Units # 5056	2003	216	43	5	43		65	59
60	2: Window Shutters - Fire Saftey # 5069	2003	3,376	225	15	225		338	60
61	Rpr 2 Floors Drain -Kitchen # 5079	2003	1,750	88	20	88		124	61
62	Rplc 91 Gal Gas Waterheater #5082	2003	2,380	238	10	238		298	62
63									63
64	Fire Sentinel-Dr Release Device	2004	1,948	141	15	141		141	64
65	Wet Sprinkler Syst Instl	2004	8,226	329	25	329		329	65
66	UseTax - Fire Sentinel A Door	2004	107	8	15	8		8	66
67	Engineering Services	2004	3,639	182	15	182		182	67
68	Fire Suppression Syst	2004	1,961	114	10	114		114	68
69	6: Zoneline Heat/ Cool Units	2004	3,434	143	10	143		143	69
70	TOTAL (lines 4 thru 69)		$ 4,368,808	$ 154,078		$ 154,078	$	$ 1,444,472	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,368,808	$ 154,078		$ 154,078	$	$ 1,444,472	1
2	Use Tax-6: Zoneline Heat/ Cool Units	2004	223	9	10	9		9	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,369,031	$ 154,087		$ 154,087	$	$ 1,444,481	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 351,943	$ 31,685	$ 31,685	$		$ 150,225	71
72	Current Year Purchases	12,428	1,301	1,301			1,301	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 364,371	$ 32,986	$ 32,986	$		$ 151,526	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activities & Medical Trans	White Ford Van 2003	2003	$ 40,166	$ 10,042	$ 10,042	$	3	$ 14,122	76
77										77
78										78
79										79
80	TOTALS			$ 40,166	$ 10,042	$ 10,042	$		$ 14,122	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,854,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 197,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 197,115	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,610,129	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	$ 2,579	$ 129	$ 914	86
87	O/H Allocation 08/01/1997	1,035	52	334	87
88	O/H Allocation 10/01/1997	117	6	37	88
89					89
90					90
91	TOTALS	$ 3,731	$ 187	$ 1,285	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 11,317 Description: Copiers, Dishwasher, ect see attachment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount		Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Mattress	5563.55		03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102				03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000				03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher	1,190.00		03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040				03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050				03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000	Mattress			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copiers, Stamp machine Cable	4,545.31		03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210				03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220	Propane Gas	18.00		04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100				03/21/03
			11,316.86		Grand Total

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	5413 hrs	$		$	$	5,413	$	1
2	Licensed Speech and Language Development Therapist	10a-03	3311 hrs					3,311		2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	7620 hrs					7,620		4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				180,521		180,521	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 180,521	16,344	$ 180,521	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Odin HealthCare Center # 0045781 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,250	$	1
2	Cash-Patient Deposits	15,010		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	742,575		3
4	Supply Inventory (priced at)	10,810		4
5	Short-Term Investments			5
6	Prepaid Insurance	170		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 769,815	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	260,000		13
14	Buildings, at Historical Cost	1,824,923		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	279,343		16
17	Accumulated Depreciation (book methods)	(349,384)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,014,882	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,784,697	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 104,845	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,415		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,881		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,124		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attachment Schd 17.1	11,446		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 343,711	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attachment Schd 17.1	(2,229,430)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,229,430)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,885,719)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,670,416	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,784,697	$	48

***(See instructions.)**

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	-
Misc Dedctns - Employee <> Union Dues <> Default	4,482
Accruals - Insurance <> Accrue HMO Ins <> Default	
Accruals - Insurance <> Self Funded Ins Accr <> Default	
Accruals - Insurance <> Basic Life <> Default	701
Accruals - Insurance <> Lt Dsblty <> Default	174
Accruals - Insurance <> Dental Ins <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	912
Accruals - Insurance <> Short Term Disability <> Default	37
Accruals - Insurance <> Dependent Life <> Default-Dept	92
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	65
Accruals - Insurance <> NES Insurance <> Default-Dept	-
Accruals - Benefits <> 401k Co Match <> Default	4,983
Total	11,446
Reconcile with schedule XV, line 36:	11,446
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	
Total	-
Reconcile with schedule XV, line 23:	0
Difference	-

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	(2,229,430)
N/P - Mortgage <> Mortgages <> Default	
Total	(2,229,430)
Reconcile with schedule XV, line 43:	(2,229,430)
Difference	0

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,782,080	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,782,080	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	888,337	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 888,337	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,670,417	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,287,415	1
2	Discounts and Allowances for all Levels	(2,376,451)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,910,964	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,712,380	6
7	Oxygen	23,602	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,735,982	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,792	13
14	Non-Patient Meals	87	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	323,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	100,026	19
20	Radiology and X-Ray	5,941	20
21	Other Medical Services	73,965	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 505,362	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts (see Sch pg 19.1)	2,376	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,376	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,154,684	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	620,600	31
32	Health Care	2,121,967	32
33	General Administration	1,077,200	33
	B. Capital Expense		
34	Ownership	184,020	34
	C. Ancillary Expense		
35	Special Cost Centers	208,208	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,266,347	40
41	**Income before Income Taxes (line 30 minus line 40)****	888,337	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 888,337	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0
Miscellaneous Receipts<>Default<>Prod<>Vending	2376
Miscellaneous Receipts<>Default<>Prod<>Administrative	-

	Total	2,376.00	Difference
Reconcile with schedule XVII, line 28:		2,376	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	

	Total	-	Difference
Reconcile with schedule XVII, line 28a:		0	-

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,947	3,041	$ 76,703	$ 25.22	1
2	Assistant Director of Nursing	1,440	1,486	30,620	20.61	2
3	Registered Nurses	9,827	10,139	213,282	21.04	3
4	Licensed Practical Nurses	19,482	20,101	336,169	16.72	4
5	Nurse Aides & Orderlies	68,074	70,239	627,751	8.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	10,078	10,437	227,510	21.80	7
8	Rehab/Therapy Aides	6,559	6,793	237,772	35.00	8
9	Activity Director	2,174	2,286	21,915	9.59	9
10	Activity Assistants	1,350	1,420	9,901	6.97	10
11	Social Service Workers	3,196	3,394	38,207	11.26	11
12	Dietician					12
13	Food Service Supervisor	2,076	2,126	23,001	10.82	13
14	Head Cook	6,785	6,949	51,933	7.47	14
15	Cook Helpers/Assistants	8,985	9,202	66,658	7.24	15
16	Dishwashers					16
17	Maintenance Workers	1,978	2,108	28,216	13.39	17
18	Housekeepers	10,599	10,979	76,203	6.94	18
19	Laundry	6,086	6,207	45,404	7.31	19
20	Administrator	3,357	3,442	91,692	26.64	20
21	Assistant Administrator					21
22	Other Administrative	2,211	2,267	31,985	14.11	22
23	Office Manager					23
24	Clerical	3,694	3,788	46,150	12.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,658	1,775	17,740	9.99	31
32	Other Health Care(specify)	3,635	3,635	68,810	18.93	32
33	Other(specify) Market/Trans	830	832	4,016	4.83	33
34	TOTAL (lines 1 - 33)	177,021	182,646	$ 2,371,638 *	$ 12.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	351	$ 13,507	1 - 3	35
36	Medical Director	144	12,500	9 - 3	36
37	Medical Records Consultant	13	578	10-3	37
38	Nurse Consultant	386	20,205	10- 7	38
39	Pharmacist Consultant	64	2,753	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	2,020	11 - 3	44
45	Social Service Consultant	42	2,334	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,037	$ 53,897		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
H. D. Henry	Administrator		$ 12,923
Jane Owens	Administrator		75,726
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,649

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Exhibit 1	See Exhibit 1	$ 10,684
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 10,684

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,493
Unemployment Compensation Insurance	63,227
FICA Taxes	178,537
Employee Health Insurance	73,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension / retirment	4,660
insurance Life	3,075
Other Benefits	7,312
Ronuding	
Home Office Allocation	
Less Employee Meals	
TOTAL (agree to Schedule V, line 22, col.8)	$ 422,718

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,926
Health Care Worker Background Check	
(Indicate # of checks performed)	2,629
Other Licenses Fees	1,029
Dues	5,584
Rounding	
Home Office Allocation	879
Total Advertising	10,133
Less: Public Relations Expense	( )
Non-allowable advertising	(10,053)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,128

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,526
In-State Travel	17,740
Home Office allocation	10,958
Seminar Expense	3,474
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,698

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Odin HealthCare Center **#** 0045781 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc -$4,831**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,535** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.